

		FOR OHF USE					

LL1

2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: 0023739</p> <p>Facility Name: ABBOTT HOUSE</p> <p>Address: 405 CENTRAL AVENUE HIGHLAND PARK 60035 Number City Zip Code</p> <p>County: LAKE</p> <p>Telephone Number: (847) 432-6080 Fax # (847) 432-7286</p> <p>IDPA ID Number: 362948048001</p> <p>Date of Initial License for Current Owners: 12/15/77</p> <p>Type of Ownership:</p> <table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input checked="" type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other</td></tr><tr><td></td><td><input type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other</td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236 - 1111</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed)</td><td></td><td>(Date)</td></tr><tr><td>(Type or Print Name)</td><td colspan="2"></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Title)</td><td colspan="2"></td></tr><tr><td>(Signed)</td><td colspan="2">See Accountants' Compilation Report Attached</td></tr><tr><td>(Print Name and Title)</td><td colspan="2">Robert A. Rose, C.P.A.</td></tr><tr><td>(Firm Name &amp; Address)</td><td colspan="2">Frost, Ruttenberg &amp; Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</td></tr><tr><td>(Telephone)</td><td colspan="2">(847) 236-1111 Fax # (847) 236-1155</td></tr></table> <p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed)		(Date)	(Type or Print Name)			Paid Preparer	(Title)			(Signed)	See Accountants' Compilation Report Attached		(Print Name and Title)	Robert A. Rose, C.P.A.		(Firm Name & Address)	Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015		(Telephone)	(847) 236-1111 Fax # (847) 236-1155	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																														
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																														
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County																																														
IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other																																														
	<input type="checkbox"/> "Sub-S" Corp.																																															
	<input type="checkbox"/> Limited Liability Co.																																															
	<input type="checkbox"/> Trust																																															
	<input type="checkbox"/> Other																																															
Officer or Administrator of Provider	(Signed)		(Date)																																													
	(Type or Print Name)																																															
Paid Preparer	(Title)																																															
	(Signed)	See Accountants' Compilation Report Attached																																														
	(Print Name and Title)	Robert A. Rose, C.P.A.																																														
	(Firm Name & Address)	Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015																																														
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155																																														

SEE ACCOUNTANTS' COMPILATION REPORT

#	0023739	Report Period Beginning:	01/01/02	Ending:	12/31/02
---	---------	--------------------------	----------	---------	----------

**D. How many bed-hold days during this year were paid by Public Aid?**

767 (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)**

N/A

**F. Does the facility maintain a daily midnight census?** Yes

YES ☐ NO ☒

YES ☐ NO ☒

**Date started** 12/15/77

YES ☐ Date \_\_\_\_\_ NO ☒

**YES**  **NO**  **If YES, enter number  
of beds certified and days of care provided**

## Medicare Intermediary

ACCRUAL	X	MODIFIED CASH*		CASH*	
---------	---	----------------	--	-------	--

**Is your fiscal year identical to your tax year?** YES ☒ NO ☐

**\* All facilities other than governmental must report on the accrual basis.**

## SEE ACCOUNTANTS' COMPILATION REPORT

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	34,496	1,642	1,061	37,199	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,496	1,642	1,061	37,199	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 96.15%

## SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ABBOTT HOUSE # 0023739 Report Period Beginning: 01/01/02 Ending: 12/31/02

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	202,581	7,883	6,720	217,184		217,184		217,184			1
2	Food Purchase		155,386		155,386		155,386	(69)	155,317			2
3	Housekeeping	134,988	15,808		150,796		150,796		150,796			3
4	Laundry	37,536	7,744		45,280		45,280		45,280			4
5	Heat and Other Utilities			59,645	59,645		59,645	279	59,924			5
6	Maintenance	90,843		73,576	164,419		164,419	(6,884)	157,535			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	465,948	186,821	139,941	792,710		792,710	(6,674)	786,036			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	677,618	43,298	3,893	724,809		724,809	(20,483)	704,326			10
10a	Therapy			4,870	4,870		4,870		4,870			10a
11	Activities	61,875	14,833		76,708		76,708		76,708			11
12	Social Services	131,573	2,815	1,566	135,954		135,954		135,954			12
13	Nurse Aide Training											13
14	Program Transportation			1,695	1,695		1,695		1,695			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	871,066	60,946	14,424	946,436		946,436	(20,483)	925,953			16
	<b>C. General Administration</b>											
17	Administrative	110,939		398,727	509,666		509,666	(287,352)	222,314			17
18	Directors Fees											18
19	Professional Services			94,067	94,067		94,067	(12,160)	81,907			19
20	Dues, Fees, Subscriptions & Promotions			46,597	46,597		46,597	(28,392)	18,205			20
21	Clerical & General Office Expenses	90,396	36,310	39,033	165,739		165,739	(21,662)	144,077			21
22	Employee Benefits & Payroll Taxes			212,387	212,387		212,387	(1,980)	210,407			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,852	18,852		18,852	(16,452)	2,400			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			26,812	26,812		26,812	87	26,899			26
27	Other (specify):*							4,976	4,976			27
28	<b>TOTAL General Administration</b>	201,335	36,310	836,475	1,074,120		1,074,120	(362,935)	711,185			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,538,349	284,077	990,840	2,813,266		2,813,266	(390,092)	2,423,174			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			47,189	47,189		47,189	(3,241)	43,948			30
31	Amortization of Pre-Op. & Org.			9,420	9,420		9,420	(9,420)				31
32	Interest			6,068	6,068		6,068	(5,246)	822			32
33	Real Estate Taxes			34,171	34,171		34,171		34,171			33
34	Rent-Facility & Grounds							7,333	7,333			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			96,848	96,848		96,848	(10,574)	86,274			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		21,628		21,628		21,628	(21,628)				41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		21,628	58,035	79,663		79,663	(21,628)	58,035			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,538,349	305,705	1,145,723	2,989,777		2,989,777	(422,294)	2,567,483			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,515)	30		9
10	Interest and Other Investment Income	(5,246)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(930)	21		18
19	Entertainment				19
20	Contributions	(1,384)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,321)	21		24
25	Fund Raising, Advertising and Promotional	(25,370)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,635)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(101,816)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (159,286)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(263,008)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (263,008)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (422,294)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ABBOTT HOUSE		STATE OF ILLINOIS	Page 5A
ID#		0023739	
Report Period Beginning:		01/01/02	
Ending:		12/31/02	
		Sch. V Line	
NON-ALLOWABLE EXPENSES		Amount	Reference
1	Non-allowable Legal	(4,668)	19
2	Miscellaneous Office Income	(241)	21
3	KOPE Dues	(1,789)	20
4	Patent Life Insurance	(3,339)	22
5	Non-allowable Seminar Expense Meals/Other	(16,452)	24
6	Bank Charges	(764)	21
7	Open House Expense	(7,480)	21
8	Trust Fees	(400)	21
9	Vending Income	(21,628)	41
10	Veterans Prescription Drugs	(15,948)	10
11	Veterans Lab Charges	(658)	10
12	Veterans Physician Charges	(3,877)	10
13	Amortization of Goodwill	(9,328)	31
14	Capitalized R&M	(6,884)	6
15	Non-Allowable Accounting Fees	(8,534)	19
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			
61			
62			
63			
64			
65			
66			
67			
68			
69			
70			
71			
72			
73			
74			
75			
76			
77			
78			
79			
80			
81			
82			
83			
84			
85			
86			
87			
88			
89			
90			
91			
92			
93			
94			
95			
96			
97			
98			
99			
100			
101	Total	(101,816)	101



STATE OF ILLINOIS

Summary B

Facility Name & ID Number     ABBOTT HOUSE     #     0023739     Report Period Beginning:     01/01/02     Ending:     12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(8,515)		5,274									(3,241) 30
31	Amortization of Pre-Op. & Org.	(9,328)		(92)									(9,420) 31
32	Interest	(5,246)											(5,246) 32
33	Real Estate Taxes												
34	Rent-Facility & Grounds			7,333									7,333 34
35	Rent-Equipment & Vehicles												
36	Other (specify):*												
37	TOTAL Ownership	(23,089)		12,515									(10,574) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												
39	Ancillary Service Centers												
40	Barber and Beauty Shops												
41	Coffee and Gift Shops	(21,628)											(21,628) 41
42	Provider Participation Fee												
43	Other (specify):*												
44	TOTAL Special Cost Centers	(21,628)											(21,628) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(159,286)		(13,913)	(133,259)	(115,836)							(422,294) 45





VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	A.H.B. D/B/A ABH MANAGEMENT	100.00%	\$ 279	\$ 279	15
16	V	6	REPAIRS AND MAINT.		A.H.B. D/B/A ABH MANAGEMENT	100.00%			16
17	V	19	PROFESSIONAL FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%	807	807	17
18	V	20	DUES, SUBS. & FEES		A.H.B. D/B/A ABH MANAGEMENT	100.00%	105	105	18
19	V	21	CLERICAL AND GENERAL		A.H.B. D/B/A ABH MANAGEMENT	100.00%	4,035	4,035	19
20	V	22	EMPLOYEE BENEFITS		A.H.B. D/B/A ABH MANAGEMENT	100.00%	1,259	1,259	20
21	V	26	INSURANCE		A.H.B. D/B/A ABH MANAGEMENT	100.00%	87	87	21
22	V	30	DEPRECIATION		A.H.B. D/B/A ABH MANAGEMENT	100.00%	5,274	5,274	22
23	V	31	INTEREST		A.H.B. D/B/A ABH MANAGEMENT	100.00%	(92)	(92)	23
24	V	34	RENT		A.H.B. D/B/A ABH MANAGEMENT	100.00%	7,333	7,333	24
25	V								25
26	V	17	HOME OFFICE	33,000	A.H.B. D/B/A ABH MANAGEMENT	100.00%		(33,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 33,000			\$ 19,087	\$ * (13,913)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - E. ROSENBAUM	\$	HEALTH RESOURCE, INC.	100.00%	\$ 48,000	\$ 48,000	15
16	V	19	PROFESSIONAL FEES		HEALTH RESOURCE, INC.	100.00%	94	94	16
17	V	27	PAYROLL TAXES		HEALTH RESOURCE, INC.	100.00%	2,042	2,042	17
18	V								18
19	V	17	MANAGEMENT FEES	183,395	HEALTH RESOURCE, INC.	100.00%		(183,395)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 183,395			\$ 50,136	\$ * (133,259)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - KARLA BISHOP	\$	KARLA BISHOP, INC.	100.00%	\$ 63,375	\$	63,375
16	V	19	PROFESSIONAL FEES		KARLA BISHOP, INC.	100.00%	141		141
17	V	20	DUES AND SUBSCRIPTIONS		KARLA BISHOP, INC.	100.00%	46		46
18	V	27	PAYROLL TAXES		KARLA BISHOP, INC.	100.00%	2,934		2,934
19	V								19
20	V								20
21	V	17	MANAGEMENT FEES	182,332	KARLA BISHOP, INC.	100.00%			(182,332)
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 182,332			\$ 66,496	\$ *	(115,836)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.     ☐ YES     ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.     ☐ YES     ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.     ☐ YES     ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.     ☐ YES     ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Earl Rosenbaum	General Partner	Admin/Bkkpr	38.71%	See Attached	10	25.00%	Admin Sal	\$ 48,000	17-7	1
2	Karla Bishop	General Partner	Administrative	12.30%	See Attached	15	37.50%	Admin Sal	63,375	17-7	2
3	Ivy Shenkman	Administrator	Administrator	0.10%	None	40	100.00%	Salary	110,939	17-1	3
4	Mitchell Rosenbaum	Maintenance	Maintenance		None	40	100.00%	Salary	41,674	6-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 263,988		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

**Ending: 12/31/02**

**Fax Number****SEE ACCOUNTANTS' COMPILATION REPORT**

**Ending: 12/31/02**

(847)432-6095

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9  Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	141,998	3	\$ 1,064	\$	37,196	\$ 279	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	141,998	3			37,196		2
3	19	PROFESSIONAL FEES	PATIENT DAYS	141,998	3	3,083		37,196	807	3
4	20	DUES, SUBS. & FEES	PATIENT DAYS	141,998	3	401		37,196	105	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	141,998	3	15,405		37,196	4,035	5
6	22	EMPLOYEE BENEFITS	PATIENT DAYS	141,998	3	4,805		37,196	1,259	6
7	26	INSURANCE	PATIENT DAYS	141,998	3	332		37,196	87	7
8	30	DEPRECIATION	PATIENT DAYS	141,998	3	20,132		37,196	5,274	8
9	31	INTEREST	PATIENT DAYS	141,998	3	(350)		37,196	(92)	9
10	34	RENT	PATIENT DAYS	141,998	3	27,996		37,196	7,333	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 72,868	\$		\$ 19,087	25

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Ending: 12/31/02**

( 847)432-6095

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Ending: 12/31/02**

( 847)432-6095

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Ending: 12/31/02**

**Fax Number****SEE ACCOUNTANTS' COMPILATION REPORT**



**Ending: 12/31/02**

**B. Show the allocation of costs below. If necessary, please attach worksheets.**

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9  Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Ending: 12/31/02**

**Fax Number****SEE ACCOUNTANTS' COMPILATION REPORT**

**Ending: 12/31/02**

**B. Show the allocation of costs below. If necessary, please attach worksheets.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Ending: 12/31/02**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**Ending: 12/31/02**

**B. Show the allocation of costs below. If necessary, please attach worksheets.**

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9  Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

**SEE ACCOUNTANTS' COMPILATION REPORT**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Bank One		X		\$783.00	07/13/01	25,000	13,936				1,432	6
7	American National Bank		X	Line of Credit-Receivables				25,000				29	7
8													8
9	TOTAL Facility Related				\$783.00		\$ 25,000	\$ 38,936			\$ 1,461	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule						75,000	47,551				(643)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$ 75,000	\$ 47,551			\$ (643)	14	
15	TOTALS (line 9+line14)						\$ 100,000	\$ 86,487			\$ 818	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1	American National Bank		X	Finance Construction	1,539	11/06/00	\$ 75,000	\$ 47,551			\$ 4,603	1	
2	Interest Income										(5,246)	2	
3												3	
4												4	
5												5	
6												6	
7												7	
8												8	
9												9	
10												10	
11												11	
12												12	
13												13	
14												14	
15												15	
16												16	
17												17	
18												18	
19												19	
20												20	
21							\$ 75,000	\$ 47,551			\$ (643)	21	

**SEE ACCOUNTANTS' COMPILATION REPORT**



IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

ABBOTT HOUSE

COUNTY

LAKE

FACILITY IDPH LICENSE NUMBER

0023739

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

(847) 236-1111

TELEPHONE

(847) 432-6080

FAX #:

(847) 432-7286

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	16-23-407-331	Long Term Care Property	\$ 41,721.80	\$ 41,721.80
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 41,721.80	\$ 41,721.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?           YES      X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates    RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

ABBOTT HOUSE

COUNTY

LAKE

FACILITY IDPH LICENSE NUMBER

0023739

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( )

FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    YES    NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

Frame

Number of Stories

1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1977	\$ 58,752	1
2					2
3	TOTALS			\$ 58,752	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1977	\$ 797,436	\$	35	\$	\$	\$ 797,436	4
5				1977	25,500		35			25,500	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1977	12,036		20	-		12,036	9
10	Various			1978	686		20	-		686	10
11	Various			1979	13,652		20	-		13,652	11
12	Various			1980	12,137		20	-		12,137	12
13	Various			1981	391		20	-		391	13
14	Various			1982	442		20	-		442	14
15	Various			1983	1,570		20	-		1,570	15
16	Various			1984	6,914		20	87	87	6,904	16
17	Various			1985	16,470		20	867	867	14,955	17
18	Various			1986	41,754		20	2,197	2,197	36,320	18
19	Various			1989	13,333		20	667	667	9,032	19
20	Various			1990	1,458		20	-		1,458	20
21	Various			1991	5,843		20	292	292	1,051	21
22	Various			1992	20,907		20	1,046	1,046	11,179	22
23	Various			1993	58,704		20	2,935	2,935	27,412	23
24	Various			1994	21,039		20	793	793	6,617	24
25	Various			1995	26,190		20	704	704	4,836	25
26	Various			1996	59,095		20	1,515	1,515	9,643	26
27	Various			1997	25,833		20	1,292	1,292	7,363	27
28	Various			1998	80,605		20	3,690	3,690	17,738	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,231	1,496		52	(1,444)	52	68
69	Financial Statement Depreciation			47,189			(47,189)		69
70	TOTAL (lines 4 thru 69)		\$ 1,244,226	\$ 48,685		\$ 16,137	\$ (32,548)	\$ 1,018,410	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

**SEE ACCOUNTANTS' COMPILATION REPORT**

**\* Assets Added after 6/30/02 Capital Projection**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,422,484	\$ 48,685		\$ 25,221	\$ (23,464)	\$ 1,036,562	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements- ABH Management			2002	2,231	1,496	20	52	(1,444)	52	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,231	\$ 1,496		\$ 52	\$ (1,444)	\$ 52	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 433,414	\$ 382	\$ 14,590	\$ 14,208	10	\$ 353,042	71
72	Current Year Purchases	35,947	3,395	2,361	(1,034)	10	2,361	72
73	Fully Depreciated Assets	8,630				10	8,630	73
74								74
75	TOTALS	\$ 477,991	\$ 3,777	\$ 16,951	\$ 13,174		\$ 364,033	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1998 LEXUS 4-DOOR	1998	\$ 65,529	\$	\$ 1,775	\$ 1,775	5	\$ 14,660	76
77										77
78										78
79										79
80	TOTALS			\$ 65,529	\$	\$ 1,775	\$ 1,775		\$ 14,660	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,024,756	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,462	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,947	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,515)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,415,255	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		Allocated from ABH Management			7,333			5
6								6
7	TOTAL				\$ 7,333			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning  
Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$
13. /2004 \$
14. /2005 \$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<div>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</div> <div><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</div> <div>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</div>	2. <u>CLASSROOM PORTION:</u>	3. <u>CLINICAL PORTION:</u>
	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
	IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
	COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
	HOURS PER AIDE _____	

B. EXPENSES

ALLOCATION OF COSTS (d)

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

		1		2		3		4	
		Facility		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$							
2	Books and Supplies								
3	Classroom Wages (a)								
4	Clinical Wages (b)								
5	In-House Trainer Wages (c)								
6	Transportation								
7	Contractual Payments								
8	Nurse Aide Competency Tests								
9	TOTALS	\$		\$		\$		\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$							

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):    See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 332,126	\$	1
2	Cash-Patient Deposits	60,766		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	675,597		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,312		6
7	Other Prepaid Expenses	7,285		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	23,816		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,155,902	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	58,752		13
14	Buildings, at Historical Cost	1,349,801		14
15	Leasehold Improvements, at Historical Cost	25,500		15
16	Equipment, at Historical Cost	555,298		16
17	Accumulated Depreciation (book methods)	(1,475,186)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	9,444		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 523,609	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,679,511	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 206,169	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,882		28
29	Short-Term Notes Payable	48,595		29
30	Accrued Salaries Payable	65,768		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,695		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,973		32
33	Accrued Interest Payable	352		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Supplemental Schedule	4,373		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 441,807	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	37,894		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Supplemental Schedule			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 37,894	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 479,701	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,199,810	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,679,511	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,234,803	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,234,803	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	585,007	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(620,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (34,993)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,199,810	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,442,824	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,442,824	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	31,473	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 31,473	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	5,246	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,246	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	95,241	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 95,241	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,574,784	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	792,710	31
32	Health Care	946,436	32
33	General Administration	1,074,120	33
	<b>B. Capital Expense</b>		
34	Ownership	96,848	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	21,628	35
36	Provider Participation Fee	58,035	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,989,777	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	585,007	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 585,007	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number     ABBOTT HOUSE

#   0023739

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,378	\$ 58,327	\$ 24.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,393	7,283	136,157	18.70	3
4	Licensed Practical Nurses	9,326	9,832	165,750	16.86	4
5	Nurse Aides & Orderlies	26,139	28,197	317,384	11.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,098	5,406	61,875	11.45	10
11	Social Service Workers	9,555	10,409	131,573	12.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,772	19,678	202,581	10.29	15
16	Dishwashers					16
17	Maintenance Workers	7,613	8,464	90,843	10.73	17
18	Housekeepers	11,321	12,597	134,988	10.72	18
19	Laundry	2,544	3,425	37,536	10.96	19
20	Administrator	2,080	2,524	110,939	43.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,067	8,034	90,396	11.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	105,988	118,227	\$ 1,538,349 *	\$ 13.01	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,720	01-03	35
36	Medical Director	Monthly	2,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,893	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	89	4,870	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	28	1,566	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	117	\$ 19,449		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		ABBOTT HOUSE		STATE OF ILLINOIS				Page 23
		#	0023739	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2)

Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount.

Yes  
IL Council on Long Term Care \$5861

(3)

Did the nursing home make political contributions or payments to a political action organization?  
If YES, have these costs been properly adjusted out of the cost report?

Yes  
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?  
What was the average life used for new equipment added during this period?

Yes  
10 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 2,373 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?  
If YES, give effective date of lease.

No

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X  
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.  
This amount is to be recorded on line 42 of Schedule V.

\$ 58,035

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  
If YES, attach an explanation of the allocation.

N/A

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?  
For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.  
Has any meal income been offset against related costs?

\$ No  
Indicate the amount. \$ N/A

(16)

Travel and Transportation  
a. Are there costs included for out-of-state travel?  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents?  
If YES, please indicate the amount of income earned from such a program during this reporting period.  
c. What percent of all travel expense relates to transportation of nurses and patients?  
d. Have vehicle usage logs been maintained?  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No  
No  
100% In 1  
N/A  
No  
N/A

g.

Does the facility transport residents to and from day training?  
Indicate the amount of income earned from providing such transportation during this reporting period.

No  
\$

(17)

Has an audit been performed by an independent certified public accounting firm?  
Firm Name:  
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?  
If no, please explain.

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?  
Attach invoices and a summary of services for all architect and appraisal fees

Yes

SEE ACCOUNTANTS' COMPILATION REPORT